# *Maryland's Comprehensive Standard Health Benefit Plan for Small Businesses*

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This pamphlet focuses on Maryland's Health Insurance Reform Act of 1993 and subsequent modifications as they apply to small businesses. This law guarantees small businesses access to health insurance. The law puts stability into their health insurance premiums. The law sets up unprecedented consumer protection. In the law, a small business is a public or private employer with 2 to 50 eligible employees. Each business decides whether or not to buy health insurance, from whom to buy insurance and whether to recover all, part, or none of the premium from its employees.

All insurance carriers participating in the small employer market must sell the comprehensive standard health benefit plan (CSHBP) to any small employer who applies for it and may sell riders to expand the covered services or lower the cost-sharing arrangements. Carriers are obligated to price the CSHBP separate from riders. Carriers may not deny coverage through the CSHBP to any individual in the group.

The following pages describe what your premiums buy in health insurance protection. Accompanying questions and answers clarify the definitions and cost controls used in the CSHBP.

Remember that a smart consumer looks at the product, the price, and the service before buying. If you feel uncertain about the meaning in any of this material or unsure of its application to you, you should ask for clarification. You can ask your insurance agent or broker or the Maryland government agencies listed in this pamphlet.

## Questions on Benefit Plan and Small Group Market

**What is the comprehensive standard health benefit plan?**

The CSHBP was developed by the Maryland Health Care Commission (MHCC). It requires all carriers to offer the same health benefits to all small employers and establishes cost sharing (e.g., deductibles, copayments, coinsurance) for various delivery systems (indemnity, preferred provider, point of service, health maintenance organization, exclusive provider, and health savings account-compatible products). By having the same benefits and cost sharing arrangements, employers are able to comparison shop. The benefits (described in this pamphlet) are comparable to what large employers now provide to their employees and offer both preventive services and protection against catastrophic loss. Employers can add benefits to the CSHBP but may not reduce them. *The Commission designs and monitors the plan so that, on average, the cost does not exceed 10 percent of Maryland's average annual wage.*

**What is meant by a delivery system?**

A delivery system refers to the way in which health care benefits under the CSHBP are received. In a traditional indemnity program, the individual selects a health care provider. In a preferred provider organization (PPO), an individual selects a specific health care provider from a panel of network providers. In a point of service system (POS), an individual must select a primary care physician (PCP) and can usually receive specialty care only with prior authorization from the PCP. In an HMO, an individual must select a PCP and can receive specialty care from a health care provider under contract with the HMO only with a referral from the PCP. PPO and POS plans permit individuals to receive care outside the network at a greater cost. An exclusive provider organization (EPO) has similarities to both an HMO and a PPO. Like an HMO, the EPO covers services that are provided in-network but, like a PPO, there is no primary care provider and no referral requirements. An EPO can be offered either with or without an HSA. In a health savings account-compatible product, the individual assumes the financial risk of a high deductible health plan (HDHP) as defined by federal law but can minimize the risk through the use of a health savings account (HSA) to which the employer, the employee, or both, subject to federal limitations, have contributed.

**How do I know which delivery system I want to have?**

You will want to talk with your insurance agent or broker or with carriers directly to fully understand the differences in access to care under these systems. You will want to talk with your current health care providers to determine with which carriers and delivery systems they participate. You will then be able to balance your own needs with cost to make your final selection.

**What are the criteria for determining a small employer?**

A Maryland small employer is any actively engaged business unit which, in the preceding calendar quarter, employed at least two but not more than 50 eligible employees on at least 50% of its working days. The majority of the eligible employees have to be employed within Maryland. The law also contains provisions to include self-employed individuals currently enrolled, certain government units, and non-profit corporations.

**Who are eligible employees?**

Any employee whose normal work week is minimally 30 hours is an eligible employee.

**What about my part-time employees or employees covered under another health benefits policy?**

Employers may elect to cover these employees under the group policy or elect to exclude these employees.

**Under Maryland's health care reform legislation, do I have to provide health benefits to my employees?**

No. The purchase of group health benefits is the employer's decision.

**If I offer group health benefits to my employees, do I have to pay for these benefits?**

No. Maryland's health care reform legislation permits employers to grant this benefit to employees and their dependents at no cost to the employer. The employer would pay the premium to the carrier but could recoup the entire premium or any portion of the premium from the employee through a payroll deduction.

**How will my premium be determined for the CSHBP?**

Carriers may not determine your premium based on the claims experience or health status of your employees. Instead, they will have to determine the premium in the same way a premium is determined for large employer groups. The claims experience of all of the carrier's small businesses will be "pooled." The carrier will determine the "community rate" based on this pool. Carriers may continue to adjust your group's premium based on the average age of your employees and the geographic location of your business. Carriers must disclose the premium for the CSHBP separately from the premium for riders.

**How do I purchase health benefits?**

Employers may purchase health benefits by contacting a carrier directly or working through an insurance agent or broker.

**Can a carrier elect not to cover my group?**

A carrier may only deny your group coverage if less than 75% of your eligible employees *who are NOT covered under a spouse's plan or another employer's benefit arrangement* elect to be covered under your group policy.

**What if I want lower deductibles, coinsurance, or copayments?**

Carriers may sell lower deductibles, coinsurance, or copayments to small employers through riders. These riders must be community rated also. Note, the HSA deductibles cannot be reduced below the federal minimums required.

**What if I want additional benefits?**

You may purchase additional benefits from carriers through riders. A carrier may require medical underwriting. These benefits must be priced and sold separately from the CSHBP. These benefits also must be community rated. The additional benefits may not reduce the benefits in the CSHBP.

**What about coverage for employees or dependents who have existing health problems?**

A carrier may not reject the employee or dependents for this reason or impose a pre-existing condition limitation. Moreover, the carrier may not charge a higher premium because of an employee's or dependent's health status.

**What if I want to offer only an HMO delivery system to my employees but some employees would prefer not to be limited to the HMO provider network?**

Under Maryland law, if the HMO is the only delivery system offered, the HMO must offer a mandatory point-of-service rider to permit enrollees to access certain services outside the network. At the time you enroll your group with an HMO, the HMO will ask if anyone in your group would like this rider. The cost of this rider may be paid by either the employer or the employee. This rider enables you to offer an HMO delivery system and offer some freedom of choice to those employees concerned about a closed-panel HMO.

**I am a self-employed individual. May I purchase the comprehensive standard health benefit plan?**

No. Effective October 1, 2005, the CSHBP is no longer offered to self-employed individuals. However, a carrier is required to offer a renewal policy to those self-employed individuals currently enrolled in the CSHBP who still work and reside in Maryland. A carrier may ask you to demonstrate that a substantial part of your income is obtained through your self-employment by requesting appropriate copies of your tax returns.

**The "Medicare Prescription Drug, Improvement and Modernization Act of 2003" has authorized the offering of health savings accounts in conjunction with high deductible health plans. Is this program available in Maryland's small group market?**

Yes, subject to carriers developing and marketing these products. Maryland's CSHBP regulations have been modified to accommodate this offering.

**What if I would like to see benefits added to or excluded from the comprehensive standard health benefit plan?**

The MHCC reviews the plan annually. The MHCC calculates the average premium to determine if it remained below 10% of Maryland's average annual wage. Based on comments received and the actual cost of the plan, the MHCC considers making changes to the comprehensive standard health benefit plan.

## Maryland's Comprehensive Standard Health Benefit Plan

The following is a ***summary*** description of the services covered.

| *Service* | *Coverage* |
|---|---|
| | |
| Ambulance Service | Covered |
| Audiology Screening For Newborns | Covered for one screening and one confirming screening |
| Blood and Blood Products | All cost recovery expenses for blood, blood derivatives, components, biologics, and serums, to include autologous services and albumin |
| Case Management Program | Available for medically complex and costly services |
| Chiropractic Services | Carrier shall pay in-network provider 70% of allowable charges (50% out-of-network) up to 20 visits per condition per year |
| Durable Medical Equipment | Covered, including nebulizers, peak flow meters, and diabetes glucose monitoring equipment |
| Emergency Room | Covered - $100 copayment (waived if admitted), plus applicable coinsurance amount |
| Family Planning Services | Covered |
| Habilitative Services | Covered, for children 0-19 years of age for treatment of congenital or genetic birth defects |
| Hearing Aids | Covered, for persons 0-18 years of age up to $1,400 per hearing aid for each hearing-impaired ear, every 36 months |
| Home Health Care | Covered as an alternative to otherwise covered services in a hospital or other related institution |
| Hospice | Covered |
| Hospitalization | Unlimited (includes detoxification) |
| Infertility Services | Coverage for services obtained after diagnosis of infertility, 50% coinsurance rate of allowable charges (excludes in vitro fertilization) |
| Medical Food | Covered for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis or treatment in the field of metabolic disorders |
| Mental Health and Substance Abuse | Covered when delivered through a carrier's managed care system for 60 inpatient days per person per year with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits |

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|---|---|
| | subject to the following cost sharing: in-network, carrier pays 70%; out-of-network, carrier pays 50% |
| Nutritional Services | 6 visits per condition per year for cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease |
| Outpatient Hospital Services & Surgery | Covered - $40 copayment or applicable coinsurance, whichever is greater |
| Outpatient Laboratory & Diagnostic Services | Covered - $40 copayment or applicable coinsurance, whichever is greater; $40 copayment or 50% of the applicable cost, whichever is less, for HMOs |
| Outpatient Short-Term Rehabilitative Services | Provided through a carrier's managed care system for a maximum of 30 physical therapy visits per condition per year; 30 speech therapy visits per condition per year; 30 occupational therapy visits per condition per year; carrier pays 70% or may substitute a $40 copayment (except federally qualified HMOs may provide 60 consecutive days). For out of network services, carrier pays 50% of allowable charges |
| Pregnancy and Maternity | Covered |
| Prescription Drugs | Generic and brand name drugs covered Deductibles = $2,500 indiv/$5,000 family Coinsurance = 75% member responsibility, 25% plan responsibility |
| Preventive Services | Covered - preventive services recommended by the U.S. Preventive Services Task Force and other services required to be offered by a federally qualified HMO |
| Skilled Nursing Facility | 100 days as an alternative to otherwise covered care in a hospital or other related institution. $40 copayment or applicable coinsurance, whichever is greater |
| Transplants | Covered, for bone marrow, cornea, kidney, liver, lung, heart, heart/lung, pancreas, and pancreas/kidney transplants |
| Well Child & Immunization Benefits | $10 copayment not subject to overall deductible for all in-network visits for children 0-24 months and for visits including immunizations for children 24 months through 13 years |

## Sample Cost Sharing Features**

| Cost Sharing Feature | PPO | EPO | HDHMO | HMO |
|---|---|---|---|---|
| ***Deductible*** | | | | |
| -Individual Coverage | $2,500 | $2,500 | $2,500 | N/A |
| -Family Coverage | $5,000 | $5,000 | $5,000 | N/A |
| ***Out-of-Pocket Limit*** | | | | |
| -Individual Coverage | $4,900 | $4,900 | $4,900 | 200% of the annua premium |
| -Family Coverage | $9,800 | $9,800 | $9,800 | |
| Lifetime Maximum Per Person | $2 mil. | $2 mil. | N/A | N/A |
| ***Coinsurance Rate*** | | | | |
| -Network | 80% | 80% | N/A | N/A |
| -Out of Network | 60% | 60% | N/A | N/A |
| Primary Care Copay | N/A | N/A | $30 | $30 |
| Specialty Care Copay | N/A | N/A | $40 | $40 |
| Inpatient Hospital Copay | N/A | N/A | $1,000 | $1,000 |
| Inpatient Physician Visit Copay | N/A | N/A | $30 | $30 |

| | | | | |
|---|---|---|---|---|
| ***Prescription Drugs*** | | | | |
| - Individual Deductible | $2,500 | $2,500 | $2,500 | $2,500 |
| - Family Deductible | $5,000 | $5,000 | $5,000 | $5,000 |
| Pharmacy Coinsurance: | 75% member responsibility<br>25% plan responsibility | | | |
| Outpatient Lab & Diagnostic Services | Greater of $40 or co-insurance amount | Greater of $40 or co-insurance amount | Lower of $40 or 50% of cost | Lower of $40 or 50% of cost |
| Outpatient Services & Surgery | Greater of $40 or co-insurance amount | Greater of $40 or co-insurance amount | $40 co-pay but not greater than the charges | $40 co-pay but not greater than the charges |
| ***HSA-Compatible PPO:*** | | | | |
| Deductible: | $2,700 indiv/$5,450 family* | | | |
| Out-of-Pocket Limit: | $5,250 indiv/$10,500 family | | | |
| Lifetime Maximum: | $2 million per person | | | |
| Coinsurance Rate: | In-Network = 80% plan responsibility<br>Out-of-Network = 60% plan responsibility | | | |
| Pharmacy Coinsurance: | 25% plan responsibility | | | |
| Outpatient Lab, Diagnostic & Surgical Services: | Greater of $40 or coinsurance amount | | | |
| ***HSA-Compatible HMO:*** | | | | |
| Deductible: | $2,700 indiv/$5,450 family* | | | |
| Out-of-Pocket Limit: | $5,250 indiv/$10,500 family | | | |
| Copayments: | $30 PCP visit; $40 specialty care visit;$30 physician inpatient visit;$1,000 hospital inpatient stay | | | |
| Pharmacy Coinsurance: | 25% plan responsibility | | | |
| Outpatient Lab & Diagnostic: | Lower of $40 or 50% of cost | | | |
| Outpatient Services & Surgery: | $40 copayment but not greater than the charges | | | |
| | | | | |
| *** Represents a unified deductible of the medical/surgical and the prescription drug deductibles** | | | | |
| **** For more detail on all plan types available under the CSHBP, contact the MHCC or refer to COMAR 31.11.06.** | | | | |

For further information regarding your own benefit plan and premiums, contact your insurance agent, broker or carrier.

For further information on the Comprehensive Standard Health Benefit Plan, contact the Maryland Health Care Commission at 410-764-3460, 1-877-245-1762 or visit the web site at http://mhcc.maryland.gov.

For additional regulatory information, contact the Maryland Insurance Administration at 410-468-2000, 1-800-492-6116 or visit the web site at www.mdinsurance.state.md.us.